Daniel Javitz, R.Ac. CTCMPAO # ____
North York_Thornhill_Vaughan Areas
(416) 671 - 2275 drjavitz.com

ACUP–NEW PATIENT INTAKE FORM (PLEASE PRINT AND FILL OUT)

FOR OFFICE USE ONLY
Date of First Visit: _____

PERSONAL INFORMATION/HISTORY — Information is Strictly Confidential — Please Answer Everything

Full Name: _____ Legal Guardian Name (if applicable):_____
Address: _____ City: _____ Province:_____ Postal Code: _____
Phone#s: Home(___)_____ Mobile/Cell:(___)_____ Business/Work:(___)_____Ext: ___
Birthdate: ___/___/___(D/M/Y) Age: ___ Sex: ❑M ❑F **Occupation/Work?:** _____
Marital Status (Check one): ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated ❑Other ‖ Children#:__
Family Doctor Name: _____ **Family Doctor phone number:** (___)_____
Emergency Contact Name: _____→Relationship to You: _____→Phone #: (___)_____
Email Address: _____ **Extended Health Insurance Company Name:**_____
How did you hear about the clinic? ❑Referral who?_____ ❑Signs where?_____ ❑Internet ❑Other_____
FOR CLINIC DIRECT BILLING: Insurance Policy#:_____ **Insurance Member ID#:**_____
Secondary Insurance Available?(i.e.Spouse's insurance?):❑YES ❑NO. **If YES, Please fill in below**
Spouse's Name → First: _____ Middle:_____ Last:_____ Sex: ❑M ❑F
Spouse's Birthdate: ___/___/___(D/M/Y) Extended Insurance Company Name: _____
Spouse's Insurance Policy #:_____ Insurance Member ID #:_____

Are you pregnant? ❑Yes ❑No If yes, how many weeks? _____ **Do you carry an epi-pen?** ❑Yes ❑No

CURRENT HEALTH CONDITION

Reason for your visit today: → ❑ Wellness/Preventative Care ❑ Relief Care/Corrective Care ❑ Curiosity/Trial

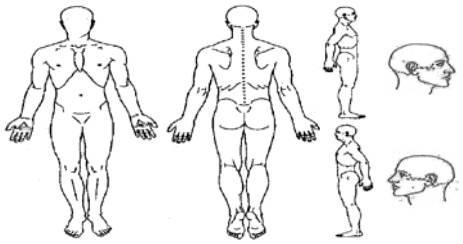
What brings you in today? List your reasons (Main Concern at the top #1)

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate — Severe

1. _____ When did it start? _____ Intensity Rating?___**/10**
2. _____ When did it start? _____ Intensity Rating?___**/10**
3. _____ When did it start? _____ Intensity Rating?___**/10**

USING THESE SYMBOLS, MARK THE TYPE OF DISCOMFORT ON THE BODY PICTURES ON THE RIGHT SIDE →

Numbness ≡≡≡≡≡≡≡ Pins and Needles ooooo
Burning xxxxxx Stabbing & Sharp ~~~~
Dull & Aching ΔΔΔΔΔΔ Stiff & Tight 22222



Regarding Your First Main Concern (#1) listed above, please answer the following questions:
How did the condition/pain begin? _____Has this condition happened before? ❑Yes ❑No
Does the condition/pain stay local ❑Yes ❑No, **OR** Does the condition/pain move to arm/leg ❑Yes ❑No
If Yes to moving pain, Please explain to where and how in your own words:_____
_____

Other Professionals seen for this condition? ❑ Medical DR ❑ Chiropractor ❑ Physio ❑ Other: _____
When was your last visit? _____ What was the diagnosis?_____
Describe your treatment history and response to the treatment (More paper can be provided upon request):
_____

Have you had X-rays or other imaging in the last 12 months? ❑Yes ❑No (What Region?):_____
Medications you now are taking: ❑Pain Killers/Muscle Relaxers ❑Antibiotics ❑Cholesterol ❑Diabetic ❑Blood Pressure ❑Blood Thinners (i.e. Warfarin/Heparin/Aspirin) ❑Anti-inflammatory ❑Antidepressants ❑Other: _____

Mark the Square if you have these Risk Factors which may affect your acupuncture treatments:
❑ **Hemophilia/Von Willebrand disease/Any other blood clotting problems** ❑ **HIV/TB/Hepatitis**
❑ **Anemia/Sickle Cell disease/Thalassemia** ❑ **Other Concern you think is a factor?**_____

Patient/Legal Guardian's Signature for both page #s 1 & 2 (Sign in the clinic) **X**_____
DR/Witness/Assistant's Signature **X**_____ DR/Witness'/Assistant's name_____

PAST AND FAMILY HEALTH HISTORY (PLEASE CHECK OR DESCRIBE WHERE INDICATED)

Try to indicate all previous slips, falls, accidents, surgeries and/or childhood traumas: _____

_____

FAMILY HEALTH	Diabetes	Heart	Cholesterol	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑	❑
Brother, # of __	❑	❑	❑	❑	❑	❑
Sister, # of __	❑	❑	❑	❑	❑	❑

Extra Details →

List all Your Allergies (Foods, Medications, Seasonal, Other)

_____

Do you take Nutritional Supplements? ❑ Yes ❑ No

If Yes, list →

Below is a health history form with a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions **MUST** be answered as these problems can affect your acupuncture care.

PLEASE CHECK-MARK '/' FOR ANY OF THE SYMPTOMS YOU HAVE NOW AND 'X' IF HAD IN THE PAST

- ☐ Anemia
- ☐ Heart Disease or Atherosclerosis
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Stroke
- ☐ Emphysema or Bronchitis
- ☐ Pneumonia or Scarlet Fever
- ☐ Alcoholism
- ☐ H.I.V. or Tuberculosis
- ☐ Hepatitis A, B, or C / Liver disease
- ☐ Diabetes or Ulcers (←Circle)
- ☐ Thyroid Problems
- ☐ Cold sores or Venereal Disease
- ☐ Appendicitis
- ☐ Arthritis or Osteoporosis(←Circle)
- ☐ Rheumatic Fever
- ☐ Polio Mumps Measles or Diptheria
- ☐ Epilepsy or Multiple Sclerosis
- ☐ Eczema or Psoriasis
- ☐ Varicose Veins
- ☐ General fatigue or weakness
- ☐ Frequent colds / flus
- ☐ Fibromyalgia or CFS
- ☐ Bad breath and / or body odour
- ☐ Night sweats

Psychosocial: Have any of the following occurred recently?

- ☐ Easily susceptible to stress
- ☐ Anger or Irritability
- ☐ Worry or Fears / Phobia
- ☐ Use of recreational Drugs
- ☐ Depression or Sadness
- ☐ Anxiety or Economic Stress
- ☐ Death
- ☐ Increased work stress
- ☐ Change of job status
- ☐ Chronic Fatigue
- ☐ Drugs / Alcohol increase
- ☐ Sleep Disturbances / Insomnia
- ☐ Poor memory / Concentration
- ☐ Family Problems or Divorce
- ☐ Mood Swings or Mental Disorder

Musculo-Skeletal

- ☐ Headaches / Migraines
- ☐ Neck pain
- ☐ Upper / Mid back pain
- ☐ Low back pain
- ☐ Shoulder pain
- ☐ Arm / Leg pain (←Circle region)
- ☐ Wrist / Elbow pain(←Circle)
- ☐ Hip / Knee pain(←Circle)
- ☐ Joint pain / Stiffness
- ☐ Ankle / Foot trouble
- ☐ Walking problems
- ☐ Difficult chewing / Clicking jaw
- ☐ General stiffness

Nervous System

- ☐ Numbness
- ☐ Dizziness / Vertigo
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Problem Speaking/Swallowing
- ☐ Blurred/Double Vision
- ☐ Clumsiness

Cardiovascular

- ☐ Chest pain
- ☐ Short breath
- ☐ Blood pressure (High/Low)
- ☐ Irregular heartbeat
- ☐ Circulatory Problems
- ☐ Lung problems
- ☐ Ankle swelling or Cold Hands/Feet

Male / Female

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping/Back Pain
- ☐ Breast pain / Lumps
- ☐ Prostate / Sexual dysfunction
- ☐ Painful/Excessive urination
- ☐ Discolored urine
- ☐ PMS? : For Female Acupuncture

Gastro-Intestinal

- ☐ Gas / Bloating after meals
- ☐ Heartburn
- ☐ Poor / Excessive appetite
- ☐ Excessive thirst
- ☐ Nausea / Vomiting
- ☐ Diarrhea / Constipation (←Circle)
- ☐ Black / Bloody stool
- ☐ Colitis
- ☐ Weight trouble
- ☐ Gallbladder trouble
- ☐ Kidney Disease or Kidney Stones
- ☐ Digestive Disorder

Eyes, Ears, Nose, Throat

- ☐ Asthma
- ☐ Frequent sore throats
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Vision problem / Bags under eyes

Lifestyle

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Satisfied ☐ Unsatisfied

Coffee / Tea

- ☐ 1-2 Daily ☐ 3-4 Daily ☐ More

Alcohol

- ☐ 1-2 Daily ☐ 3-4 Daily ☐ More

Cigarettes

- ☐ 1-2 Daily ☐ 3-4 Daily ☐ More

Sleep Position

- ☐ Side ☐ Back ☐ Stomach

Do you have a regular exercise program?

- ☐ Yes, Describe: _____

_____

- ☐ No

Lifestyle Stress Levels

- ☐ High ☐ Moderate ☐ Very little

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INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I, or the person listed below, have discussed with my Traditional Chinese Medicine Practitioner or Acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine / Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, gua sha, and Tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.

2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discoloration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.

3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.

4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.

5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.

6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered unless other payment methods have been discussed and agreed on between the practitioner / the clinic and myself.

7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

Dated this ____ day of _____ , 20___

_____ _____

Patient Signature (Legal Guardian) Witness Signature

Name: _____ Witness Name: _____

(Please Print) (Please Print)

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I _____ , or my appointed representative _____
Print Name Print Name

❑ CONSENT ❑ DO NOT CONSENT ← Please Check One Option

For the above Clinic and / or Practitioner to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.
In terms of information, the Clinic may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used
Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information
I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

Acknowledgment
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used / disclosed if mandated by law.

Additional Comments or Restrictions:

_____

_____

Dated this ____ day of _____ , 20___

_____ _____
Patient Signature (Legal Guardian) Witness Signature

Name: _____ Witness Name: _____
(Please Print) (Please Print)